WIC INFORMATION MANUAL
FOR
PROSPECTIVE DRUG STORES

July, 2001

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT:

AGENCY _____

ADDRESS _____

_____

TELEPHONE NUMBER _____

CONTACT PERSON _____

DEVELOPED BY:

DEPARTMENT FOR PUBLIC HEALTH

DIVISION OF ADULT AND CHILD HEALTH

NUTRITION SERVICES BRANCH

WIC PROGRAM

275 EAST MAIN STREET

FRANKFORT, KENTUCKY 40621

IN ACCORDANCE WITH FEDERAL LAW AND U.S. DEPARTMENT OF AGRICULTURE POLICY, THIS INSTITUTION IS PROHIBITED FROM DISCRIMINATING ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE OR DISABILITY.

TO FILE A COMPLAINT OF DISCRIMINATION, WRITE USDA, DIRECTOR, OFFICE OF CIVIL RIGHTS, ROOM 326-W, WHITTEN BUILDING, 1400 INDEPENDENCE AVENUE, SW, WASHINGTON, DC 20250-9410 OR CALL (202) 720-5964 (VOICE AND TDD). USDA IS AN EQUAL OPPORTUNITY PROVIDER AND EMPLOYER.

INTRODUCTION

What is WIC? WIC is a supplemental food program funded by the United States Department of Agriculture and administered through the Kentucky Cabinet for Health Services. WIC services are coordinated through Local Health Departments and private health facilities.

The WIC Program provides specific nutritious foods along with nutrition education at no cost to the participant. These services are provided to income eligible and nutritionally at risk pregnant, breastfeeding and postpartum women, infants and children up to five (5) years of age.

The goals of the WIC Program are: (1) to improve the outcome of high risk pregnancies by decreasing low birth-weight babies, (2) to decrease the incidence of anemia and poor growth patterns; and (3) to improve the dietary habits of its recipients. Each applicant must be certified by a physician, nurse or nutritionist to be at nutritional risk in order to be admitted to the program. Once a client is certified, the parent, guardian, caretaker or proxy receives nutrition education counseling and food instruments, which are redeemable at stores in Kentucky that have a WIC contract.

Participants are issued food instruments for one (1), two (2) or three (3) month periods, but should redeem only one (1) month of food instruments at a time. Participating vendors redeem these food instruments for approved food and deposit the food instruments in their bank just as they would a check.

The WIC vendor is an important part of the WIC Program and it is necessary that all drug stores who apply to become WIC vendors understand the WIC Program rules and regulations.

This manual was prepared for drug stores who wish to make application to become an approved WIC vendor. Please read everything carefully. **If you are accepted, you will enter into a written Agreement with the WIC Program and be responsible for carrying out ALL terms of the contract as well as WIC Program Policies and applicable Federal and State Regulations.** Your contracting agency will be the Local Agency that administers the WIC Program in the county where your business is located, hereafter referred to as the Local Agency.

WIC INFORMATION MANUAL FOR PROSPECTIVE DRUG STORES
TABLE OF CONTENTS

	Page
HOW TO BECOME A WIC VENDOR	1
KENTUCKY WIC PROGRAM DRUG STORE APPLICATION	3
INSTRUCTIONS FOR COMPLETING THE WIC PROGRAM DRUG STORE APPLICATION (WIC 14b)	8
INSTRUCTIONS FOR COMPLETING THE WIC APPROVED ITEMS PRICE LIST FOR DRUG STORES (WIC 24b)	11
INSTRUCTIONS FOR COMPLETING THE WIC PROGRAM DRUG STORE VENDOR AGREEMENT (WIC13b)	12

Rev. 7/01

HOW TO BECOME A WIC VENDOR

Before a drug store can be an authorized vendor and accept food instruments, the drug store must:

A. **Complete a Kentucky WIC Program Drug Store Application (WIC-14-b)** which provides the Local and State Agency with general information and ensures that the prospective applicant meets the criteria for selection, which includes the following:

1. **Drug stores** must be able to supply formula within **forty-eight (48) hours of verbal request**. See Attachment A of the Vendor Agreement.

2. Not be disqualified or withdrawn by the United States Department of Agriculture (USDA) from participation in another Food and Nutrition Service (FNS) Program or the Medicaid Program or denied application to participate in the Food Stamp Program or the Medicaid Program. Not be currently paying a civil money penalty to the Food Stamp or Medicaid Program; or not having been assessed a civil money penalty for hardship by the Food Stamp Program and the disqualification period that would otherwise have been imposed has not expired.

3. Direct distribution outlets and wholesale food establishments are not eligible. In order for one of these firms to be authorized, the applicant must have a recognized pharmacy section in a stationary location that is a separate and distinct area.

4. **Being open for business year round, on a full time basis, at least eight hours per day and six days per week.**

5. Not owing the WIC Program for any unpaid claims or civil money penalties for any stores owned or previously owned by the applying owner.

6. The State agency may not authorize an applicant vendor if, during the last six (6) years, the vendor applicant's current owners, officers, or managers have been convicted of or had a civil judgment for:
   a. Fraud;
   b. Antitrust violation;
   c. Embezzlement, theft, or forgery;
   d. Bribery;
   e. Falsification or destruction of records;
   f. Making false statements or claims;
   g. Receiving stolen property;
   h. Obstruction of justice;
   i. Other evidence reflecting on the business integrity and reputation of the applicant; or
   j. Official records of removal from other federal, state or local programs.

7. The WIC Program shall not authorize a store that has attempted to circumvent a period of disqualification from the program. This includes a store that has undergone a sale or change of operation if the transaction involves the following parties:
   a. The seller or transferor is an owner, operator, or manager who is currently suspended, sanctioned, or disqualified from WIC or the Food Stamp Program; and

b. The buyer or transferee is related to the seller by marriage or consanguinity within the fourth degree, or was a manager or employee of the seller at the time the sanction, suspension or disqualification was issued or the violation occurred.

8. No contract shall be entered into with a provider when a conflict of interest, real or apparent, will occur. Contracts will not be entered into with local health department employees or with governing local board of health members.

9. The State agency will terminate a vendor contract if it determines the vendor or vendor's employees provided false information in connection with the vendor application.

B. **Complete a** Price List for Drug Stores (WIC-24b).

C. **Receive an on-site visit by the Local Agency** to verify information submitted on the Application and Price List.

D. **Review and sign a Drug Store Vendor Agreement (WIC-13b).** The Application and Vendor Agreement will be reviewed with the applicant by the Local Agency and then submitted to the State Agency for approval.

E. **Provide additional information** such as a bill of sale, tax return information, other proof of ownership or other documents as requested.

F. **Receive training** on the operation of the WIC Program.

G. **Receive an authorized WIC Vendor Stamp from the Local Agency, along with a copy of the signed and approved Drug Store Vendor Agreement (WIC-13-b).**

NOTE: AN APPLICANT CANNOT ACCEPT WIC FOOD INSTRUMENTS UNTIL THE SIGNED AND APPROVED AGREEMENT AND WIC VENDOR STAMP IS RECEIVED. NO PAYMENT WILL BE MADE TO AN APPLICANT WHO HAS NOT SUCCESSFULLY COMPLETED THIS PROCESS.

WIC-14b
7/01

DATE OF REQUEST:_____

KENTUCKY WIC PROGRAM DRUG STORE APPLICATION
Please Print unless otherwise indicated.

ALL QUESTIONS ON THE APPLICATION MUST BE PROPERLY AND FULLY COMPLETED. PLEASE REVIEW THE WIC

INFORMATION MANUAL FOR PROSPECTIVE DRUG STORES FOR INSTRUCTIONS ON COMPLETING THIS FORM.

1. STORE NAME _____

2. **PHYSICAL STORE ADDRESS:**

   STREET # _____ STREET NAME _____

   CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

3. **MAILING ADDRESS (Do not complete if mail can be delivered to the store's physical location.):**

   STREET # _____ STREET NAME _____

   RURAL ROUTE NUMBER/P.O. BOX

   CITY_____ STATE _____ ZIP CODE_____

4. **STORE TELEPHONE NUMBER:** ( )_____
   Area Code Number

5. **TYPE OF OWNERSHIP (Check One):** ☐ Single Owner ☐ Partnership ☐ Corporation

6. **OWNERSHIP INFORMATION:**

   A. **CORPORATION NAME AND ADDRESS (For any business that is incorporated):**

   CONTACT PERSON: _____ , _____ TITLE: _____
   Last Name First Name

   BUSINESS NAME: _____

   STREET#/NAME: _____

   P.O. BOX: _____

   CITY: _____STATE: _____ZIP CODE: _____

   TELEPHONE NUMBER: (_____)_____
   Area Code Number

Privacy Act Statement: The collection of the Social Security Number (SSN) is authorized by Section 2018 of Title 7, US Code and will be used to determine whether a store qualifies to participate in the WIC Program, to monitor compliance with Program regulations; and for Program management. The provision of the SSN's will be available only to officers and employees whose duties or responsibilities require access for the administration or enforcement of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) and the Food Stamp Act.

   B. **OWNER(S) NAME(S), SOCIAL SECURITY NUMBER(S) AND TELEPHONE NUMBER(S):**

(Complete for single owners, partnerships, principal shareholders of private corporations, corporate officers, etc. Include spouse, if spouse is considered an owner. Attach a listing if more convenient.)

Name_____ , _____SSN _____Home Phone_____
Last Name First Name

Name_____ , _____SSN _____Home Phone_____
Last Name First Name

Name_____ , _____SSN _____Home Phone_____
Last Name First Name

Name_____ , _____SSN _____Home Phone_____
Last Name First Name

7. **MANAGER (if different from Owner):** _____, _____ _____
Last Name First Name Social Security Number

8. When did (or will) the store open for business under the applying ownership? ☐☐ ☐☐ ☐☐
Month Day Year

9. How long has this store been in business? _____

Was this store previously operated under another name or owner? ☐Yes ☐No

If yes, indicate store name and owner of store:

_____, _____
Name of Store Owner

Was the store ever on the WIC Program? ☐Yes ☐No

10. Are you (applicant) related to the previous owner? ☐Yes ☐No If yes, what is the relationship: _____

11. Have you (Applicant) ever previously participated in the WIC Program? ☐ Yes ☐ No
If yes, specify the date, the previous authorized WIC number (if known) and the store name (attach a list, if necessary):

Date: _____ Previous WIC Number: _____ Name of Store: _____

12. Including this store, have you (Applicant), the corporation or the manager ever owned, managed or been an employee of a firm which was disqualified or terminated from the WIC Program? ☐Yes ☐No
If yes, specify the date, the reason and identify the person(s) or corporation, store name and location involved.

Date: _____ Reason: _____

Name of Store: _____

Person(s)/Corporation: _____

Address: _____

13. Do you (applicant) own or manage any other grocery or drug stores that are currently contracted with WIC? ☐ Yes ☐ No
If yes, list the name and address of the store(s). Attach a list, if necessary.

Name of Store _____

Address: _____

14. a. Are you authorized to accept Food Stamps? ☐Yes ☐ No
If yes, Food Stamp Authorization Number: _____

b. Are you a Medicaid provider? ☐Yes ☐ No
If yes, Medicaid Provider Number: _____

15. Including this store, have you (Applicant, the corporation or manager) ever owned or managed a firm which violated the Food Stamp regulations, received a warning letter or was withdrawn, disqualified, assessed a civil money penalty or fined? ☐Yes ☐ No
If yes, specify the date, the reason, and identify the person(s) or corporation, the store name and location involved.

Date: _____ Reason: _____

Name of Store: _____

Person(s)/Corporation: _____

Address: _____

16. Has the Owner, corporation or manager ever had a license denied, withdrawn, suspended or been fined for license violations (i.e., business or health licenses)? ☐Yes ☐ No
If yes, list the type of license, the reason for and date of denial, fine, suspension, withdrawal or disqualification.
Type of License: _____ Reason: _____ Date: _____

17. BUSINESS ETHICS: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager, or 6) any stockholder who has a substantial role in the operation of the store? **If yes**, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity, and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served, and any other relevant information.

18. Indicate the number of cash registers: _____

Do any of these cash registers have optical scanners? ☐Yes ☐ No

19. IS THIS STORE OPEN YEAR-ROUND? ☐Yes ☐ No

If NO, check the months when the store is OPEN:

☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

20. HOURS OF BUSINESS:

Monday	___ A.M.	to	___ P.M.
Tuesday	___ A.M.	to	___ P.M.
Wednesday	___ A.M.	to	___ P.M.
Thursday	___ A.M.	to	___ P.M.
Friday	___ A.M.	to	___ P.M.
Saturday	___ A.M.	to	___ P.M.
Sunday	___ A.M.	to	___ P.M.

21. List the bank of deposit that will be used for WIC food instruments and the complete address of the bank:

Bank _____
Branch Name _____
Street _____
City _____ State _____ Zip _____

22. Provide directions to the store from the Health Department in the county where the store is located (Provide highway numbers rather than stating 'Route 1, etc.').

_____
_____
_____

23. Is the store name visible on the outside of the store? ☐Yes ☐ No
Indicate name on sign or store front if different than name on the front of this application:

_____

24. Can you (applicant) supply all of the formulas listed on Attachment A to the Drug Store Vendor Agreement within 48 hours of verbal request? ☐Yes ☐ No

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SUPPLIED BY ME ON THIS APPLICATION AND THE ATTACHED PRICE LIST IS CORRECT. IF IT IS DETERMINED THAT THE INFORMATION SUPPLIED IS NOT CORRECT OR THAT, IN REVIEW OF THE INFORMATION SUPPLIED, THE STATE AGENCY FINDS THAT MY STORE DOES NOT MEET THE CRITERIA TO BE A WIC VENDOR, MY STORE WILL NOT BE APPROVED FOR A CONTRACT. I UNDERSTAND THAT, SHOULD MY STORE BE ACCEPTED FOR A WIC CONTRACT, I WILL BE BOUND BY WIC PROGRAM REGULATIONS AND POLICIES. **I UNDERSTAND THAT THIS IS ONLY A REQUEST FOR PARTICIPATION AND DOES NOT CONSTITUTE A CONTRACT AND I WILL NOT ACCEPT WIC FOOD INSTRUMENTS UNTIL I HAVE RECEIVED AN APPROVED WIC PROGRAM AGREEMENT AND AN AUTHORIZED WIC VENDOR STAMP.** THIS APPLICATION WILL BE A PERMANENT PART OF MY FILE.

_____ _____
AUTHORIZED SIGNATURE **(Applicant OR CORPORATE OFFICER ONLY)** DATE

_____
TITLE

****
****

LOCAL AGENCY USE ONLY

The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applicant has actually taken possession of the store and the property transfer has been completed.

1. Review Drug Store's SRP listing(s). (Does/Do) the SRP listing(s) have an extensive list of formula?
☐Yes ☐ No

2. Verify the Price List with the shelf or display case prices, if applicable.

3. Is this store primarily a drug store? ☐Yes ☐ No If no, then explain: _____

4. Warn the applicant that he/she is not an Authorized WIC Vendor and cannot accept food instruments until the authorized stamp is obtained and training has been completed.

5. Comments: _____
_____
_____

I CERTIFY THAT I HAVE VISITED THIS DRUG STORE AND FIND IT (☐ ELIGIBLE / ☐ NOT ELIGIBLE) BASED UPON THE CRITERIA FOR SELECTION OF VENDORS AND THE VENDOR AGREEMENT. IF THIS VENDOR IS NOT ELIGIBLE, PLEASE DOCUMENT WHY:

SIGNATURE OF LOCAL AGENCY _____ DATE: _____

****
****

STATE AGENCY USE ONLY

1. Date Food Stamp information verified: _____ Food Stamp Number: _____
   Date Medicaid Provider Number verified: _____Medicaid Provider Number: _____

2. Does the drug store meet the Criteria? ☐Yes ☐ No
   If no, explain: _____
   _____
   _____

3. Recommended for approval? ☐Yes ☐ No

4. Additional Comments: _____
_____
_____

5. Signature _____ Date _____

INSTRUCTIONS FOR COMPLETING THE VENDOR PORTION OF THE WIC PROGRAM DRUG STORE APPLICATION (WIC-14-b) REV. 6/01

Upon request, a Local Agency will provide the applicant with an Application (WIC-14b) and a WIC Approved Items Price List for Drug Stores (WIC-24b). **The Application and Price List must be properly and fully completed and returned to your Local Agency. ALL QUESTIONS ON THE APPLICATION MUST BE FULLY COMPLETED. DO NOT ACCEPT WIC FOOD INSTRUMENTS.**

The Local Agency will complete the Date of Request.

A. The following instructions are for completing the vendor portion of the Application:

1-4. Self-explanatory.

5. **Type of Ownership -** Check the type of ownership which most closely fits.
(1) Single Owner - owned by 1 person
(2) Partnership - owned by 2 or more people
(3) Corporation - Incorporated with the State

6. Ownership Information:

a. Supply the name and address of the corporate contact, corporate name and address. This applies to any business that is incorporated.
b. **Name(s), Social Security Number(s) -** Name and telephone number(s) of person(s) who are partners or corporate officers and the Social Security Number of each person.

7. Self-explanatory.

8. **Store Open for Business Under Applying Ownership -** Indicate the specific date (month, date, year) the store will or has opened under the applying ownership.

9. **How Long the Store has Been in Business -** If the store has previously been in business, enter the time period. If previously in business under another name or owner, please indicate. Also, indicate if the store previously participated in the WIC Program.

10. Self-explanatory.

11. **Participation in WIC Program -** Indicate if the applicant has ever had a contract with the WIC Program. If yes, indicate the previous WIC Vendor Stamp number (if known) and the store name. Stores currently contracted with the WIC Program are to only be included in the answer to number 13 of this form.

12. **Warning or Suspension from WIC Program -** Indicate if the applicant, the corporation or the manager ever owned, managed or been an employee of a firm which ever was terminated or disqualified by the WIC Program. If the applicant has never been a WIC Vendor, enter N/A (not applicable). If yes, provide date, a brief reason and identify the person or corporation and the store name and location involved.

13. **Own Other Grocery or Drug Stores -** If yes, indicate name(s) and address(es) of any other stores owned that accept WIC food instruments.

14. **Authorized to Accept Food Stamps or a Medicaid Provider** - If authorized, supply the Number.

15. **Suspension from Food Stamps or Medicaid -** Indicate if the applicant, the corporation or the manager ever owned or managed a firm which has violated Food Stamp Regulations or Medicaid Regulations and was withdrawn, disqualified, assessed a civil money penalty, fined or received a warning letter. If the response is no, enter N/A. If yes, provide the date, a brief reason, and identify the person or corporation and the store name and location involved.

16-19. Self-explanatory.

20. **Hours of Business -** Hours the store is actually open each day.

21. **List Bank of Deposit -** Indicate the name and complete address of bank of deposit.

22-24. Self-explanatory.

25. **Review paragraph.**

26. **Authorized Signature (Owner or Corporate Officer) - The applying owner must sign this form.** The only exception is for a chain store whose Authorized Representative is at the corporate level and may not be the owner.

27. **Title -** Title of person signing application. **The applying owner must sign this form.** The only exception is for a chain store whose Authorized Representative is at the corporate level and may not be the owner.

28. **Date -** Date the form is signed.

B. The next two (2) portions of the Application are for the Local Agency and State Agency to use in reviewing your store for approval for a contract. **Do not complete these portions of the form.**

C. The Local Agency will review the store's eligibility and submit the application information to the State Agency, **only <u>if</u>** the store is eligible according to the criteria they have reviewed. **If the store does not meet the criteria after two (2) site visits, the store may not apply for the Program for sixty (60) days from the date of denial.**

D. **Within thirty (30) days of receipt of a properly completed Application from the Local Agency,** the State Agency will review the Application, Price List, verify information with the Food Stamp Office and the Medicaid Program. The State Agency may request a bill of sale, tax return information, other proof of ownership and/or other documents.

E. If there is a problem with the Application and/or the store does not meet the criteria to be a WIC Vendor, the applicant will be notified either by the Local Agency or State Agency. **If the store does not meet the criteria to be a WIC Vendor after two (2) reviews, at any time during this process, the store may not apply for the Program for sixty (60) days from the date of denial. After three (3) reviews, the store may not apply for the Program for one hundred and twenty (120) days from the date of denial. Each subsequent denial results in an additional sixty (60) days; i.e., four (4) denials-180 days, etc.**

INSTRUCTIONS FOR FORM – WIC 24b

1. **Vendor Number –** An applicant leaves the area blank.

2. **Date Completed -** Enter the numerical month, date and year on which you are completing the Price List. For example, April 6, 2000=040600

3. **Name of Vendor -** Print the name of your store.

4. **Prices** - Prices are to be entered for the formulas that are in stock and the formulas that can be ordered upon special request for the WIC Program. **Use the suggested retail price per unit for items that are special ordered.**

5. **Signature of Store Contact -** Signature of person providing information.

6. **Title of Store Contact -** Title of person providing information.

Rev. 11/96

INSTRUCTIONS FOR COMPLETING THE WIC PROGRAM
DRUG STORE AGREEMENT

This document constitutes a written contract between the Local Agency, State Agency and the participating WIC vendor, regarding applicable federal and state regulations relating to the WIC Program.

A. For an applying vendor:

1. **Review this document in its entirety before signing the Agreement. This is a legal and binding contract.**

2. Sign the following lines:

a. **Authorized Signature - the signature of the owner.** If the store is part of a chain, the legally authorized obligating corporate authority signs.

b. **Title** - the title of the person signing the Agreement.

c. **Authorized Signature** - type or print legibly the name of the person signing the Agreement.

d. **Corporate or Business Name** - type or print legibly the name of the corporation or business.

B. One (1) copy of the original Agreement will be provided for your files and reference when it has been approved by the State Agency. **AN AGREEMENT IS NOT VALID UNTIL IT HAS BEEN SIGNED AND APPROVED BY THE STATE AGENCY AND YOU HAVE RECEIVED YOUR VENDOR STAMP. YOU MAY NOT ACCEPT WIC FOOD INSTRUMENTS UNTIL YOU HAVE RECEIVED A VALID AGREEMENT AND YOUR VENDOR STAMP.**

C. **The WIC Program Drug Store Vendor Agreement is <u>not</u> a license or property interest.**